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# MEDICAL AND SURGICAL REPORTER

No. 1675.

PHILADELPHIA, APRIL 6, 1889.

VOL. LX.—No. 14.

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## CLINICAL LECTURE.

### NERVOUS DYSPEPSIA.<sup>1</sup>

BY EDWARD T. BRUEN, M.D.,

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ASSISTANT PROFESSOR OF PHYSICAL DIAGNOSIS IN THE UNIVERSITY OF PENNSYLVANIA, AND PHYSICIAN TO THE PHILADELPHIA AND GERMAN HOSPITALS.

I shall bring before you only one case this morning, not so much for the lessons which may be drawn from the study of the case in itself as for the purpose of describing the method of clinical study which should be pursued in the analysis of the symptoms, especially by means of certain chemical tests which have been recently suggested as very useful in such cases.

Dyspepsia, it is well known, is a term like albuminuria, or dropsy, or anemia; it is a name which may embrace very many totally different pathological conditions.

For our purpose we may divide dyspepsias

<sup>1</sup> Delivered at the German Hospital.

into three groups: (1) those in which there is a lack of secretion of hydrochloric acid; (2) those in which there is an increased secretion of hydrochloric acid; (3) those in which there is a want of nerve power, or a sympathetic nervous dyspepsia attended by the formation of a variable amount of hydrochloric acid.

Cases which belong to the first group are frequently those of gastric carcinoma; not because this process exerts any mystical influence to prevent the formation of HCl, but because the later stages of carcinoma of the stomach are attended with atrophy of the gastric follicles. The constant presence of HCl in anything like normal quantity is the best evidence which can be given that gastric carcinoma does not exist. There are, however, other cases of gastric disorder in which HCl is deficient. In the amyloid process, and in circulatory diseases which favor portal repletion the secretion of HCl is much reduced. In chronic gastric catarrh the same process of reduction in the elaboration of HCl occurs. The form of dyspepsia associated with chronic gastric catarrh must

therefore be differentiated from malignant disease.

The dyspepsias of the second group include chiefly gastric ulcer. Indeed gastric hyperacidity is believed to be a predisposing cause of gastric ulcer. This hyperacidity may not only arise from the over-production of HCl, but lactic acid, which exists in the stomach during the earliest stage of the digestive process, and is frequently formed during the digestion of food by fermentation, may also be a factor in causing the hyperacidity which so commonly precedes the development of gastric ulcer. Various other organic acids may be formed during the process of faulty digestion, but the presence of the others does not so commonly antedate gastric ulcer as does the excess of HCl.

The third class of dyspepsias includes the cases which are represented by the patient we have before us at this time. This form of the complaint is often met with in factory girls, or those who work in shops. These persons are apt to be confined too closely, have little out-door exercise, often eat improperly, and generally use tea and coffee to excess, or eat coarse food in large quantities, or hurriedly. Such persons are especially predisposed to dilatation of the stomach, which may render their dyspepsia really incurable.

This dilatation occurs because of the constant accumulation of gases formed during the process of fermentation of food in the stomach. This form of dilatation may be also traceable to regurgitation of gases from the intestine, in certain cases of intestinal indigestion, so that the stomachic indigestion is secondary. All the forms of dilatation of the stomach mentioned might be denominated functional, to distinguish them from the forms of dilatation secondary to pyloric obstruction directly dependent upon cancer, or chronic inflammatory pyloric thickening after ulcer, or obstruction dependent upon the pressure of some tumor adjacent to the pyloric orifice.

A chemical analysis of the gastric contents should be instituted when practicable at the outset of the examination. If possible the patient's stomach should be washed out in the evening, and on the following morning a test-meal should be given consisting of an egg with bread and butter, and some hot milk, water and sugar as the beverage. In an hour after the test-meal a soft flexible tube, eighteen or twenty inches long—that is, a tube one-third or three-eighths of the length of the body—should be introduced

into the stomach. The tube may be lubricated with milk, and the patient can learn to assist in the introduction of the same by swallowing efforts. Light pressure over the stomach may then be made, and with the effort of regurgitation on the part of the patient about one ounce of the gastric fluid can be brought up. If this method of obtaining the contents of the stomach fail, the stomach-pump may be used. The introduction of the tube will often occasion vomiting. The gastric contents being obtained they should be filtered, and Uffelmann's test employed. This consists of a four per cent. solution of carbolic acid with four drops, or sufficient tincture of the chloride of iron to produce a steel blue color. The filtered gastric fluid should be dropped into the solution very slowly, a yellow color being produced by lactic acid, and decolorization in the presence of HCl. Since it is possible for decolorization to be caused by other acids than HCl, Uffelmann's test should be reserved for lactic acid, while for hydrochloric acid Günzburg's test should be used. This consists of fifteen grains of vanillin and forty grains of phloroglucin mixed in one ounce of alcohol. With a trace of mineral acid, it produces a yellowish-red color. By dropping some of the solution into the filtered contents of the stomach, the HCl present will form a precipitate of bright red crystals. If the proportion of mineral acid is very minute, equal quantities of the solution and juice should be employed, and it will be necessary to evaporate the liquid slowly in a porcelain crucible. A deposit around the edges of fine red crystals will then be obtained. Heat should be applied with the spirit lamp, care being taken that the liquid that is testing does not boil. When the gastric liquid contains considerable quantities of albuminates or peptones the isolated crystals are not observed; but the bright coloring persists and the crucible is covered with a mixture composed of albuminates and fragments of crystals.

For clinical purposes the phloroglucin-vanillin test is perfectly reliable, though Faucher<sup>1</sup> concludes from some experiments with eggs of various degrees of freshness—prepared by mixing their whites with a given weight of distilled water—that though new-laid eggs give a negative reaction with the phloroglucin-vanillin, eggs five days old become rose colored; three eggs of doubtful freshness gave an intense, dark-red color;

<sup>1</sup> *Journal de Mtd.*, Paris, August 12, 1888.

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in short, the intensity of the reaction was in proportion to the age of the egg, which contains an increasing quantity of sulphuric acid as it becomes stale. Dr. F. Spaeth has devised a very simple apparatus for testing the presence or absence of HCl. He takes a small bullet (No. 6) and wraps about it a silk thread (No. 1), which he has previously soaked in a 0.015 per cent. watery solution of Congo red. To this is fastened also a small piece of elder-pith which has been soaked in blue litmus paper. The whole is attached to a long silk thread. The bullet and pith-ball are swallowed and allowed to remain in the stomach for a minute, and then drawn up. Any acid present turns the litmus pith to red, while if free HCl is present it turns the Congo-red thread a blue color. Acetic and butyric acids can be detected by the smell, especially after the fluid is shaken with ether, and the ethereal residue evaporated.

The patient whom I bring before you this morning is a woman, 28 years old, who complains of pain over the epigastric region, loss of appetite for the last two years; she has vomited blood once. The patient has lost forty-five pounds in weight, and is quite anemic—weighing now only one hundred and eight pounds.

Malignant disease may be set aside as unlikely to be present on account of the age of the patient. Gastric ulcer can be excluded because the pain is diffused over the whole stomachic region. Vomiting of blood has occurred only once. Localized tenderness is absent, and vomiting has been only an occasional not a constant symptom. But the analysis of the gastric contents shows a normal proportion of HCl, and such an analysis is a very helpful measure in the diagnosis.

I have prescribed for this patient:

R. Ext. belladonnae . . . . .	gr. i
Argenti nitrat. . . . .	gr. ii vel iii
Fiant pil. No. xii.	

Sig. One pill 15 minutes before each meal.

The diet should be Malted Milk, as made by the Racine firm, or Carnrick's Soluble Food. Very carefully watched these preparations may be used to represent milk, but the patient should be weighed every week, to note any gain or possible loss.

This treatment has been successful in the present case. We have cautiously added first slightly boiled eggs, then meat broiled, then well-baked bread. Milk itself can be very rarely used in these cases, since it is liable to cause vomiting. It is for this

reason that the foods named are so valuable as temporary substitutes for milk. I say temporary, since I would never regard an artificial preparation as fully representing standard milk; but they are of great value in bridging over a certain period of time. When neither milk nor these substitutes I have mentioned can be tolerated, one may resort to broiled meats with *zwiebach*, or toasted bread. I have no doubt that attention to the diet will suffice to cure this patient; and it must be remembered as a cardinal point in these cases never to give more food daily than can be digested.

*February 1.*—This patient has been discharged, having gained in weight fifteen pounds and nearly regained her natural appearance as to complexion. At present the patient has no symptoms of gastric indigestion. It will be necessary for her to observe the injunctions to be careful of her diet for some months to come.

It will now be possible to begin with the series of remedies calculated to reestablish the crasis of the blood, such as arsenic in small doses, iron, and the like. I would simply remark that it is well to give these remedies for a long time, and therefore a small dose is very desirable. I usually give at this stage of the treatment some *nux vomica*, and possibly zinc as a nerve tonic, as in the following pill:

R. Acid. arseniosi . . . . .	gr. ss
Ferril sulph. exsic. . . . .	gr. v
Zinci sulph. . . . .	gr. iii
Ext. nucis vomice . . . . .	gr. v
Ext. gentianæ . . . . .	gr. xxx

M. Ft. pil. No. xxx.

Sig. One pill 3 times a day.

In closing, I would call attention to the fact that I employ pepsin but little, while I lay stress on the fact that dietetic treatment is all important. Pepsin may be used as an adjuvant to diet, but not as a principal mode of treatment. The effect of acids and alkalies is very doubtful in cases of chronic nervous dyspepsia. It is said by some that they precipitate the mucus and in the long run lessen the formation of HCl and the peptic ferment. Alkalies are said to dissolve mucus, and to promote the secretion of HCl and the peptic ferment. My own opinion is that both modes of medication are adapted only to temporary use, and that in cases of prolonged functional dyspepsia they may even be injurious.

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—Prof. Wilhelm Henke has accepted the Chair of Anatomy in the University of Gratz.

## COMMUNICATIONS.

### FLAT-FOOT: A NEW PLANTAR SPRING FOR ITS RELIEF.

BY A. SYDNEY ROBERTS, M.D.,

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Among the most distressing and painful deformities of the lower extremity, which the orthopædic surgeon is called upon to treat, cases of flat-foot stand foremost. I should not have ventured to speak of this very common deformity, did I not think that its importance is often overlooked, and that in many instances it is a source of much confusion regarding its etiology, diagnosis and treatment to those who have not had many opportunities for studying the disease.

As a rule the ordinary forms of club-foot are unattended with pain; this symptom entering only secondarily, either as a result of pressure from walking in the deformed position, or from the faulty mechanical appliances used to correct the deformity. In the form of talipes under consideration, however, pain plays an important part, and with this the disability produced is often so extreme as to render the patient unable to pursue his ordinary occupation. Thus, in addition to the usual end to be attained in the treatment of deformities of the feet, namely, the restoration to the normal form of the foot, we have another and more practical object, demanding our utmost attention and study, and that is the preservation of the means of livelihood to those who are unfortunately afflicted with flat-foot.

Like other forms of talipes, flat-foot, or talipes valgus, may be a congenital or acquired malformation, but it is very rarely found at birth to such an extent as to be considered pathological. On the other hand the acquired forms of valgus, taking all the varieties collectively—whether occurring as simple flattening of the arch, as secondary to rachitis, as the result of infantile spinal paralysis, or those of the inflammatory type—talipes valgus probably occurs most frequently of all the distortions of the feet.

It may be well, in this connection, before proceeding to an account of the etiology of talipes valgus, to give a brief account of the normal mechanism of the foot and of the

plantar arch. All of that portion of the lower extremity situated below the tibiotalar articulation enters into the construction of the foot, and in the adult has the form of an arch, with its convexity or dorsal surface above and its concavity or plantar surface below. At the highest point of this arch, which is formed by the astragalus, the weight of the body is received and transmitted; receiving the weight on its trochlear surface from the tibia, and transmitting it through the so-called pillars of the arch. Of these there are two, the anterior one composed of the scaphoid, three cuneiform and the three inner metatarsal bones, being the longer, less oblique and more elastic. The posterior pillar, formed by the os calcis, is shorter and thicker, its concavity being directed inward, and it is less elastic than the anterior one. The astragalus, therefore, may be regarded as the keystone of the arch, but it differs in certain respects from the keystone of the ordinary arch. Whilst its anterior surface by its opposition to the concave posterior surface of the scaphoid fulfils this requirement, posteriorly it rests upon and overrides the os calcis. Hence, this weak point in the arch has to be supplemented, so to speak, and this is accomplished by the soft parts, the interosseous ligaments, passing between, and binding together the bones, the calcaneo-scaphoid ligaments arising from the inferior surface and forepart of the os calcis, and passing to the posterior and under part of the scaphoid bone, thus giving direct support to the head of the astragalus. Again, we have a secondary arch, supporting the primary one. This is formed by the outer part of the os calcis, the cuboid, and the two outer metatarsal bones, this supplementary arch being supported by the calcaneocuboid ligaments, whilst the strong plantar fascia extends between and acts as a brace to the pillars of the arch. It must not be forgotten that while an arch has ordinarily to receive weight only in one direction, in the case of the foot the direction of the weight is continually changed by the various positions assumed by the body in its movements. Thus, while in the standing position, the weight would fall chiefly on the astragalus and be directly transmitted to the two pillars of the arch; in walking, running, dancing, etc., involving as these movements do the different parts of the foot, the weight is constantly shifted, and consequently the ligaments and muscles of the foot are called upon to reinforce the arch by their action. Added to this there is the mobility of the

tarsus, and this mobility is the greatest just where the greatest strain falls, namely, between the astragalus and scaphoid. The muscle principally called upon in this connection is the tibialis posticus, whilst the inner part of the calcaneo-scaphoid ligament is chiefly engaged in resisting all extra strain.

It will be easily understood then, that, associated with the different complex movements alluded to, involving as they do the raising (flexion) and placing of the foot on the ground (extension), that on the resistance offered by the tibialis posticus, and calcaneo-scaphoid ligament, and upon the help thus given to the arch, depend the conservation of the form of the foot. Again, the normal curves of the foot give a certain amount of mechanical advantage in the distribution of the superincumbent body weight. Thus, in flexion, the two curves of the foot, the larger with its concavity downward, and a lesser one along the inner side of the foot with its concavity outward, are increased. On the other hand, in extension, as when the foot is firmly planted on the ground, both these curves are diminished and the foot flattened. It is evident, therefore, that any cause operating to weaken those tissues, which, by their aid, serve to strengthen the arch, will cause a permanent extension of the foot, with obliteration of the natural curves. Thus, in occupations requiring continued standing or walking, or the maintenance of a given position for a long time, these structures become overtaxed, and as a consequence do not afford the proper accessory support to the arch; there exists a condition of permanent extension of the foot and sooner or later, depending on the constitution of the individual, flat-foot follows as a consequence of this abnormal strain.

The morbid anatomy of flat-foot, or spurious valgus, shows differences according to the etiology of the given cases. Thus, in the congenital variety very few pathological changes are noticeable. The external appearance of the foot shows a decided lowering or flattening of the normal arch, with the inner margin of the foot depressed and closer to the ground, whilst the outer border is raised, and the anterior part of the foot everted. Sometimes in these congenital cases there is a marked degree of equinus associated with the valgus, and when this occurs, there is decided contraction of the calf muscles. In the congenital form of valgus, there is not much displacement of the bones of the foot, the principal

changes consisting of the elevation of the tuberosity of the os calcis, while the astragalus is pushed downward and forward, and is seen as a prominence on the inner side of the foot, with the rotated scaphoid bone, which is also prominent. There is a slight rotation outward of the cuboid bone, and the malleoli are depressed, being found on a lower plane than normal. The weight of the body coming on these disturbed relations is not properly received and transmitted, and, as a consequence, the strain becoming too severe on those tissues which serve to assist the arch, there is a resulting stretching of the ligaments on the plantar and inner side of the foot. Thus, the calcaneo-scaphoid ligament especially, which bears the brunt of resistance to displacement and is constantly called upon in this connection, becomes relaxed. In the congenital form, although the muscles show few changes, with the continuance of the affection there often ensues a marked contraction of the peronei and calf muscles, the foot then taking the form of an equino-valgus. With this there is often found a contraction of the extensor longus digitorum, the extensor pollicis, and the abductor minimi digiti, with slight alterations in the relations of all the tendons of these muscles.

The forms of flat-foot which deserve most of our attention will come under those found in the acquired variety, and these are the cases which, from the unusual suffering and disability they occasion constitute a large and important class. They have been variously called "splay-foot," "spurious valgus," "inflammatory flat-foot," "tarsalgia of adolescents," etc. In children the acquired form of valgus usually met with is the result of a poliomyelitis anterior, and in this condition the anterior tibial and adductor muscles are usually the paralyzed ones. At times, as in the congenital form, there is a coincident contraction of the calf muscles, rendering the deformity a compound one, and we have a talipes equino-valgus. It is also found very often associated with knock-knee and bow-legs, as a mechanical result of these deformities, especially in rachitic subjects. Rachitis itself is a very prolific source of this deformity, while as a symptomatic condition in ankle-joint disease, after injuries and burns of the foot, and following rheumatism, flat-foot is of frequent occurrence.

Each one of these causes must be made out and its relations to the deformity closely studied, but the limit of this paper is too

short to give an extensive account of each variety. It is the condition variously named as already stated, that I wish to emphasize particularly.

While to the experienced orthopaedist flat-foot is not especially difficult of detection, to one who has not seen many cases it frequently presents puzzling symptoms. Thus, it is frequently mistaken for neuralgia, rheumatism, and even for chronic osteitis of the tarsal bones, and I have had patients who have been treated for all these conditions before the real cause was diagnosed. They are met with generally at the period of adolescence, although I have had several cases in which the patients were between forty and sixty years of age. In occupations necessitating long continuance of one position, as is the case in bakers, machinists, clerks, waiters, weavers, or in those vocations which compel constant and fatiguing motion, as in soldiers, the deformity happens frequently. Growing boys and girls, especially those of a languid disposition with an especial tendency to the accumulation of adipose tissue, are especially liable to this painful trouble. Certain races seem prone to this affection, namely, the negro and the Jewish races.

The gait and attitude of patients suffering with this trouble are characteristic and easily recognized. They have a heavy, dragging gait, the knees being bent, and the feet are placed in a careful, gingerly way on the ground, so that all the weight possible shall be kept from the tender part. When such patients step on an uneven surface the pain complained of is of an excruciating nature, and walking or standing is avoided as much as possible. The patients are easily tired and have an anxious expression of countenance, the general condition sympathizing to such an extent with the local trouble, that, in certain instances, the nutrition of the patient suffers very markedly. This is not difficult to understand when we reflect that, occurring as it does in young people generally active, and at a time of life when the desire for exercise and enjoyment is at its height, the enforcement of comparative idleness by the pain experienced prevents the proper completion of those functions which give the system at large its elasticity and tone.

The morbid changes found in the acquired form of flat-foot, are those which are found associated with the special etiological factors entering into the production of the deformity. For a long time it was supposed that the painful variety, in which

we are especially interested, was due to an osteitis, but no absolute evidence of an inflammatory lesion, such for instance as that seen in the head of the femur in *morbus coxarius*, has been found. Still, I have seen cases in which, on rotation of the tarsus, marked reflex spasm of the abductor muscles was occasioned. If any osteitis be present, it would seem to me to be of the nature of dry, or caries sicca. In none of the cases that I have seen have there been evidences of suppuration, the local symptoms at times showing swelling, especially below the malleoli, with a semi-fluctuating feel; but heat is generally absent. On the contrary the feet of flat-footed people are, as a rule, cold, and have a peculiar, dark-blue look, as though the venous circulation was badly accomplished. The appearance of the bones is such that pressure in the deformed position would amply account for them. They are not especially altered in their relative positions, although, with the gradual falling of the arch, the astragalus becomes slightly displaced downward, the scaphoid and internal cuneiform bones being brought to a lower plane than normal, and nearer the ground. It is at the inner side of the foot where the astragalus and scaphoid show prominently, that, as a rule, the greatest amount of pain is experienced; but the location of the pain is by no means constant, the transverse tarsal joint, the metatarso-phalangeal articulation, and even the calcaneum being at times the seat. With the continuance of the abnormal pressure and the bony changes due to it, there is seen a gradual destruction of the normal arch. The abductor muscles begin to contract strongly, while the adductors are in a condition of functional paresis, and thus added to the flattening of the foot we have abduction, and a constant condition of extension; and if the contraction of the abductor muscles be maintained the outer edge of the foot is raised and does not touch the ground. In the extreme degrees of the affection the instep becomes totally obliterated through the loss of the convexity of the arch, and the internal malleolus especially becomes more and more prominent, and is seen with the protuberant astragalus and scaphoid bones as a prominence on the inner side of the foot.

In this condition, I have found, taking the medio-tarsal joint as a base line of measurement, and erecting upon this a perpendicular corresponding to the long axis of the os calcis, that the angle of internal deflection is reduced from twelve degrees in

moderate cases to five degrees in severe ones. From an examination of severe cases I have ascertained the average deviation from the perpendicular to be about eight and two-tenths degrees.

The prognosis in cases of flat-foot depends in a large degree on the causes which occasion the deformity, the surroundings of the patient, and the time when he comes under treatment. In the congenital form of the disease, when it is not of great severity, the prognosis is usually a favorable one, but the severer cases, and those which have been allowed to go on for a long time, are usually more resistant, and often necessitate protracted treatment. In the acquired form, occurring as it usually does in the poorer classes, although the wealthy are by no means exempt, and being mostly met with in those who are dependent for their support on their vocation, the prognosis is not so favorable, many of these cases not coming under treatment until the pain becomes excessive, and the deformity far advanced. Still, where the hygienic and other surroundings can be improved and the patients placed under favorable conditions, and when the disease is not the result of incurable paralysis or of chronic joint lesions, I know of no disease in which so much can be done for the relief of pain, and in which such gratifying results can be accomplished, although much time and patience may be necessary for the removal of the deformity.

Concerning the treatment of flat-foot very little need be said regarding the congenital type of the deformity. When seen shortly after birth the patients may be successfully treated by manipulations alone, these having for their object the carrying of the foot to a more inverted position. To retain the advantage gained by these movements molen-skin adhesive plaster (Maws), with a roller bandage may be employed to draw the foot into the varus position. When the deformity is more severe, and the child older, external splints of a simple character, composed of tin, gutta-percha, or hatters-felt may be employed. These are moulded to the part, and a gradual inversion of the foot accomplished. Should contractions occur, which cannot be overcome by the use of the simple means mentioned, tenotomy of the peronei and extensor longus digitorum becomes necessary. Should the tendo Achillis be contracted this will also have to be cut. These operations, however, are best divided into two stages, the peronei and extensor longus being tenotomized first,

and the tendo Achillis subsequently. Massage and electricity to the weakened tibial muscle may also be resorted to with the greatest advantage. When the child is old enough to walk, a simple support, consisting of two lateral uprights, connected with a band to encircle the calf, and with an inner pad corresponding to the axis of the astragalo-scaphoid articulation, and attached to the bottom of the shoe, may be used.

The forms of flat-foot which we shall be called upon to treat frequently are those which belong to the acquired variety. Here our treatment will, of course, be governed by the cause producing the deformity, and by the amount of pain and deformity. I have, already, in discussing the etiology of the disease given a brief account of the different causes operating to produce flat-foot, and will not dwell at length on the differentiation of these causes, but simply remark here that any constitutional causes or diatheses—whether strumous, rachitic or tubercular—should receive careful attention. Neither will it come into the province of this paper to discuss those extreme instances of valgus which, having been neglected for years, present so much deformity that nothing but exsections of the displaced tarsus will suffice for a restoration to a useful foot. The symptomatic valgus seen in the course of ankle-joint disease or osteitis of the tarsus, generally yields to the treatment employed for the primary lesion.

It is to the inflammatory form, so called, that I will place especial stress in the matter of treatment. I have already alluded to the difficulty of obtaining *rest* for these cases, owing to the fact that they for the most part occur in the working classes, where daily labor is necessary for their support. Where it can be done the removal of the patient from all employment suffices, especially, in beginning cases, to promote a rapid cure; but even in these cases some support to the weakened arch is called for. This has been accomplished in several ways, either by inserting pieces of leather, pads of different material and construction, steel-tempered bars, and springs on the plantar surface of the foot.

While relief can undoubtedly be afforded by these means, there are objections to their use; chief among these being the expense of especially constructed shoes and the introduction of these various contrivances. Of all those mentioned, however, I have had the best results from the use of tempered springs so made that the convexity of the spring shall be at that point where the arch

of the foot is most flattened. These I have had made to extend from the middle of the os calcis to the base of the metatarso-phalangeal articulation, and their object is to supply an artificial arch for the foot. They have, however, to be inserted as a shank into the shoe, and this necessitates the construction of a special boot, and oftentimes the making of a special last for the patient. Again, being very narrow they do not, when there is extreme flattening, give the desired amount of support, patients often feeling the necessity for more pressure than can be given by them. I am indebted to Mr. Arthur H. Lea for an improvement on this spring, and it gives, undoubtedly, the best support of all the contrivances I have used, or am acquainted with.



Fig. I. Upper surface of spring.

The artificial arch illustrated in the cut is made of tempered steel. An outline of the patient's foot is first taken, on stencil-board, the tracing being extended upward on the inner side of the foot. The elevated portion, corresponding to the depressed arch of the foot, can be tempered to the extent required by the particular case. The lateral pressure brought to bear by the elevated flanges is such, that, whilst giving support to the arch to a certain extent, the artificial arch also prevents further displacement of the astragalus and scaphoid. Again, in place of giving only a limited amount of support to the inner side of the foot, this appliance supports the foot as a whole. The objection argued against the narrow spring is entirely avoided by the use of this one. It can be placed in any shoe and changed at pleasure. In most of the cases in which I have used it the spring is simply inserted into the shoe without any fastening whatsoever. The transition from absolute disability to comparative

freedom from pain which the use of this simple contrivance affords is surprising, and it is all the more gratifying from its simplicity and easy adaptability. Where the disease has lasted for a long time, I sometimes combine with it the ankle support

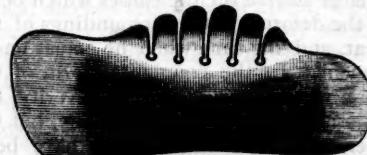


Fig. II. Under surface of spring.

mentioned, and it often serves as a valuable adjuvant in cases in which the muscles and ligaments are fatigued from long use in the deformed position.

I cannot close these remarks without enjoining the necessity of proper massage and electricity to the weakened parts. Much good also may be done at times by the use of rubber bands, especially in those cases in which the tibialis anticus is in a paretic condition. Concerning the use of plaster of Paris for the redressment of the foot, I would simply say that the chief objection against its use lies in the fact of its compelling the patient to keep his bed, and so depriving him of the benefit of fresh air and sunlight—both good adjuvants to the other treatment recommended.

#### COMPLICATIONS FOLLOWING ABDOMINAL SECTION.<sup>1</sup>

BY J. M. BALDY, M.D.,  
PHILADELPHIA.

The attention of surgeons, in the past and at present, has so commonly and almost exclusively been called to the perfection of the different abdominal operations, that the possible complications which may follow have been lost sight of, or, if noticed at all, they are kept locked up in the bosom of the individual himself, and the profession at large hears and consequently knows very little about them. In consequence of this, medical men are continually running across these patients, and are having their faith in the value of the original operation shaken. Most men go into an operating room, see the operation, have a pathological specimen shown them, and then go away, satisfied as to the justifiability of the operation and confident as to the results. They may or

<sup>1</sup> Read at the meeting of the Obstetrical Society of Philadelphia, March 7, 1889.

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may not see the patient several times during the treatment, but are generally satisfied with an inquiry as to how the patient is progressing, and finally have the satisfaction of hearing that she is well and has been discharged. The case is probably reported as cured to some society or medical journal, and thus the favorable statistics are swelled, and inexperienced and untrained men are led into attempting the operation, usually with the result of sacrificing several lives, before they are frightened off.

It is about time for surgeons to look at and seriously study some of the dark sides of abdominal surgery; for a dark side it certainly has. Our results, as far as removing disease is concerned, are about perfected; let us now turn some of our energies into preventing or alleviating some of the after-complications, which are in many cases as bad as the original disease itself. They do not probably cause such immediate danger to life, but produce symptoms just as hard to bear, as far as the patient is concerned, and to her belief, fully as bad at times, as her former trouble.

When I first began to give special attention to gynecological surgery, especially the abdominal variety, I was considerably worried that my cases did not always run as smooth and uncomplicated a course as I had been led to believe that those in the hands of my friends and others did. That they were not perfectly well when they got up, and came to me sometimes for weeks, complaining of one thing or another, was a source of great mortification to me. And finally, I began to find that troubles continued and others appeared, which it was extremely difficult to control. At first, supposing that I was the only one so afflicted, I thought there must be something radically wrong, either with my operations, or with my handling of the case afterward; and yet I could not reconcile these thoughts with the fact that I usually had the very best of assistance at the operation, and the constant advice of most competent men in the conduct of the after-treatment. Now I am constantly seeing and hearing of cases with troubles similar to my own, and also some with complications I have never personally met with. These cases are by no means confined to the practice of any one man, or any class of men, but represent patients of nearly every prominent operator in this city. Nor do I think that these results are confined to Philadelphia, but that they will be found wherever abdominal surgery is practised.

To consider fully the causes, prevention,

and cure of these complications, is beyond the scope of this paper; my object being simply to call general attention to their frequency and to make a few remarks on the most common of them. Some of the subjects have been, from time to time, noted by other surgeons, and have been called to the attention of the profession, only to be dropped, almost as if they were subjects not to be handled and publicly discussed. Among the most frequent of these might be mentioned: hernias; simple fistulous tracks; fecal fistulas; pain, pelvic or abdominal; edema of the lower extremities. I have seen many patients suffering from all of these troubles, and have had some of them follow in my own practice.

Holmes has found that he had thirty per cent. of hernias following his operations. Now as these cases were for the most part hospital patients, he could certainly not have kept track of them all, and so if the whole truth were known the per centage would be much higher. It would seem, at first sight, that a patient developing a ventral hernia would return for treatment; but not so, for in my own experience, with the exception of one patient, none of them ever reported, and I only discovered their existence from outside information. Thirty per cent. is, I think, a fair average of hernias following section. Most of the operators, with whose work I am familiar, have, I am confident, almost if not quite that proportion. I know of many cases in this city, of which the operator himself is not yet cognizant. Now a ventral hernia is by no means a harmless thing. I can recall women who suffer almost as much from the presence of the hernia as they did from the original disease—in fact more so; one case I know of had originally a small unadherent ovarian cyst, found in the course of a general examination, and which gave her few if any discomforts; she now has a good-sized ventral hernia, from which she suffers considerably. These hernias constantly tend to increase in size, and when the woman is one who must be on her feet constantly, carrying heavy burdens, lifting heavy weights, or in fact doing anything which will increase the tension at the abdominal opening, the result must invariably be a rapid enlargement of the protrusion, with all the accompanying distresses. There is no good reason why some of these hernias should not eventually, from various causes, become strangulated, and require a second and more serious operation; this has indeed actually occurred. The mere protrusion and displacement have

caused so much trouble that an operation has been devised for the closure of the opening.

The causes of hernia have been somewhat a matter of dispute; some contending that the drainage tube is most at fault, while the advocates of the tube repudiate that idea. Then again improper suturing is charged with the results. Whatever the cause, the lesion is certainly a lack of union of the muscular tissues and of the deep fascias; the remedy is plainly that of securing perfect apposition of the edges of these tissues. Time is frequently a most important element in an operation, and there is no need of wasting it by passing a separate row of sutures, in the peritoneum itself, as has been advocated and practised in some of our neighboring cities. The peritoneum always unites, and does so in a very short time. As far as I know, it has never failed to do so, excepting in those cases in which the whole incision failed. The hernia is always found to have a covering of skin, superficial fascia and peritoneum. It seems to me that a continuous catgut suture of the muscles and deep fascia is all that is needed, beyond the usual all-the-way-through suture. I can recall a case in which the presence of a hernia, by demanding an operation for its closure, resulted in the death of the woman.

This city now contains a large number of women with fistulous tracks in their abdomens. Some of these have followed the use of drainage tubes and others have been produced by abscesses that have ruptured through the incision, leaving a track which has never closed. The extra-peritoneal method of treating the pedicle in hysterectomy is a very frequent cause of fistula. The length of time it takes the clamp to come away is often so great as to leave an opening, which constantly discharges pus—in small quantities it is true, but yet enough to be exceedingly annoying and uncomfortable to the patient. I have had two such fistulas following hysterectomy, and neither of them have I yet been able to cure; one, however, now gives fair promise of soon closing. I have, fortunately, had no other fistulae following my operations.

One patient I know of was a few years ago operated on for some pelvic trouble, and after a few weeks she was sent to her home, with a drainage tube (rubber, I think) in her abdomen. The surgeon lost sight of her, and the tube being neglected, soon became most foul. The patient afterward drifted into one of our large general hospitals and there died.

Another patient was operated on for a pus

tube; the second tube and ovary, being apparently healthy, were left *in situ*, but these afterward took on disease and a second operation failed to remove them. A third operation was undertaken, by another surgeon, with what result was never known except by a select few; certain it is that a fistulous track followed, after a severe illness. This woman also finally found her way into one of the general hospitals, and was miserable enough to die, if she did not do so; what finally became of her I do not know.

A third patient had one side of a double tubal trouble removed, and the drainage track never closed. I saw this woman a year or more after the operation, on her death bed. The track was discharging pus freely, and always had done so; before her death, feces were also finding their way through the opening, a slough having evidently come away from the bowel.

A fourth patient, after everything else had been done without success, had a counter opening made into the vagina, by another surgeon into whose hands she had fallen. The operation, unfortunately, opened the bladder, so high up that it was impossible to repair it; she has now a vesico-vaginal fistula in addition to her other troubles, and at last report was in a dying condition.

And so I could go on with case after case, some as bad and some not so bad; but at its best, a fistula is a most miserable complication and too much attention cannot be given to its prevention. If the drainage tube is not responsible for the hernias, it certainly is for a large number of the fistulas; and although I am a firm believer in the great benefits to be derived from free drainage, I fully realize its disadvantages and often wonder if it could not be done away with oftener than it is. The great preventative of the formation of these fistulas is the prevention of abscesses and the necessity of their subsequent discharge; if they do form, it is better to go boldly in and empty them at once, than to wait and have them open by a slow, tedious and uncertain process, which may not be brought to an end before the patient dies; the avoidance of the unnecessary use of the drainage tube, and when it is used, the most careful attention to its cleanliness, and its early withdrawal. I believe a permanent track results oftener from an unnecessarily prolonged use of the tube, than from any other cause.

Fecal fistulas are not so common, and yet enough of them occur from time to time to

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be a warning of the danger of their production. When they do occur, they are usually so deeply seated and so bound around by inflammatory products that they cannot be reached, and if they are reached, as a rule, they require one of the most dangerous and difficult operations in the whole range of abdominal surgery. I can recall a number of these accidents: one could not be reached after an extended trial, and the whole incision was closed up in order that the patient might die as quietly as possible; this she did not do, however, but lived in spite of everything and the track afterward closed of its own accord. Another case required the most constant and careful irrigation, after an unsuccessful attempt had been made to reach it, to save the woman's life. And so they go; if an attempt is made to close them, a great risk is taken; if they are let alone and do not close spontaneously, the patient had better be dead. The usual cause, as far as I have been able to observe, is intestinal adhesions to diseased organs. After tearing a loop of gut loose, I have returned it in fear and trembling, lest a piece at the point of adhesion slough out and give me a fecal fistula. The prevention consists in the greatest care in tearing loose each adhesion, and a most careful attention to the after treatment. When fistulae occur, they are best left alone.

A continuance of pain, or the appearance of a pain not before present, following abdominal section, is so common that every one engaged in this kind of surgery must have noted its frequency. This pain is usually not very severe, but is of a constant nagging character, such a one as so constantly to wear on a woman's nervous system that it soon renders life a misery to herself and makes her a burden to every one around her. At times, however, it assumes a severe character and becomes almost unbearable. I have known of a large number of such cases, some of which required an operation for their relief. In two cases of this kind the only lesion found was an omentum adherent to the abdominal incision, the freeing of which cured the pain. Many others are now going about, suffering as much as they did before the operation. Most of this pain is, I believe due to adhesions formed between the omentum or intestines and raw surfaces left by the operation, and the subsequent dragging on these points. This would seem to be true, as most of the cases which I have known of and which were operated on, and in which the adhesions were released, have been cured, or nearly

so. I also think that the adhesions in the original disease often cause most of the suffering; this is especially true in the pelvic cases. From these same adhesions, we have sometimes an obstruction of the bowels, either at once or later, after convalescence, which results in death. I can remember several cases of this kind, which could be explained in no other way and, in fact, some of which were demonstrated to be so by a *post-mortem* examination. The remedy for their formation and all their attendant dangers and discomforts, is to keep the bowels soluble, so that there can be no chance for adhesions to occur. The best way of accomplishing this is by purgatives, and by not using opium. Fortunately the indications for purgatives are so many and so constantly present, that they can almost always be used.

Cedema of the lower extremities, I have seen a number of times. Sometimes it is only temporary but at others it is of long enough duration and severity to be of considerable annoyance and worry to both patient and surgeon. In my own practice this has occurred several times, but has always eventually disappeared.

When every person, about to undergo an abdominal operation, must run the gauntlet of all these complications, as well as many more unmentioned, it becomes a serious matter in deciding for or against an operation. We have here to consider more than the immediate risks to life; we must think, if the patient has his or her present disease removed, will she be any better off, or may she not be the worse for the interference? At any rate, such a state of affairs should be a warning to inexperienced men not to be misled by the brilliant reports seen in the journals, and not to rush thoughtlessly into an operation, expecting to obtain the same perfect results. They should know that, as a rule, only favorable cases are reported, and that men do not like to publish to the world their bad work or misfortunes. Abdominal section is by no means the simple, easy procedure some men would make us believe, and such an operation should never be undertaken except after the most careful consideration of all the risks that must be run, the chances of benefit to the patient, and in the presence of actual demonstrable disease. Until the dark sides of abdominal work are well known to the profession at large, the *furore operandi*, which has been so justly complained of, will continue, and many women will succumb as the results of inexperience.

## TREATMENT OF TAPEWORM.

BY TRAILL GREEN, M.D.,  
EASTON, PENNSYLVANIA.

The treatment of tapeworm as given in the *REPORTER*, March 9, is doubtless very effectual when the remedy can be obtained in its active state, but, as stated, "is perhaps a little severe." Pomegranate has been used with very good results, but a decoction of ten ounces is a larger dose than many of our patients would be willing to swallow. You know I am fond of a palatable medicine. The active properties of pomegranate to meet the treatment of tapeworm can be put in less than an ounce of a liquid. I have used the remedy from the time of its introduction, and it has not failed in a single case. I introduced it to the members of our County Medical Society, who have used it with similar success.

Professor Laboulbene, member of the French Academy, who has made the cure of *tænia* a specialty, but who found it difficult to get good preparations of the medicines which are active in the recent state, wrote: "I wish that some one would discover and separate from the taenicide plants a sure alkaloid, always identical, and that would act with certainty; which is something we cannot obtain from pomegranate bark, or from old koossoo, which is nearly inert." (*Bulletin de Thérapeutique*, 1877.)

M. Tanret obtained the alkaloid from pomegranate bark, and named it pelletierine, in honor of Pelletier, the distinguished French chemist to whom we are indebted for so many valuable discoveries in organic chemistry.

The alkaloid has been used with great success in several of the Hospitals of Paris. Dr. Dujardin-Beaumetz has reported thirty-three cases, of which thirty-two were successfully treated. Professor Laboulbene treated fourteen cases and the tapeworm was expelled in every case. I have never used a taenicide which is so certain to bring away the whole creature—head and body. I very confidently tell a patient: "Soon after taking the medicine you will pass the tapeworm"; and my promise has not failed.

I write this that the members of our profession who have not heard of this remedy may have the pleasure of using that which will be satisfactory to themselves and grateful to their patients. I doubt not they meet with these cases frequently; I find that they

are much more common than they were thirty or fifty years ago.

French physicians use with the pelletierine a French purgative, which is not official with us. I find an ounce of Epsom salt to act very well.

## LYCOPODIUM DRESSING FOR ULCERS AND WOUNDS.

BY C. P. EDWARDS, M.D.,  
GRANITEVILLE, S. C.

During the years 1862, 1863 and 1864 we, as Confederate medical officers, were in want of the usual antiseptic dressings to wounds and ulcers, and were thus taught to experiment with various articles of the *materia medica* in the hope of finding what would take the place of remedies such as the phenol preparations. Our supply of these accepted antiseptics was cut off by reason of the blockade; our hospitals were crowded with wounded, and our accommodations were tents, churches, and private buildings. The warm and moist climate attracted numerous flies which were nourished and fostered by suppurating wounds of every nature, and with all of our care we would sometimes find a nest of their larvæ in a wound, which would render our patients frantic with unrest.

These were readily routed by applications of oil of turpentine. But the important feature was to guard these wounds with a substance of a protective nature, which embodied the greatest amount of cleanliness. Hence the ointment made from our common elder flowers was adopted, but found objectionable from the unctuous matter used as a vehicle.

Having amused myself by covering water with a coating of lycopodium, and getting the ignorant to introduce their finger through this coating and to withdraw it from the glass in a dry condition, with the lycopodium covering the finger, as with the encasing of a kid glove, I suggested to my esteemed friend, Surgeon W. S. Meire, that we should adopt lycopodium as a dressing to freshly amputated stumps. That night we amputated twelve arms and legs, and having closed the wounds *secundum artem*, viz.: with sutures and adhesive straps, we applied lycopodium freely, and had the satisfaction of seeing eleven out of the twelve wounds heal by first intention.

Since then I have relied upon lycopodium as a dressing to all wounds, and in December, 1888, I was pleased with its application

to a lacerated wound made by a cotton card to the forearm. During January, 1889, I used it twice—once in amputation of the thumb, with laceration of the back of the hand, the second time in a laceration of the palmar surface. Both wounds healed by first intention.

Let each surgeon now ask himself: What is lycopodium? Sulphur is death to insects. Lycopodium is a vegetable sulphur. In twenty-six years' use of it, I have never had any bad results in treating surgical wounds with it. I would therefore respectfully ask a trial of it by the other surgeons of our country, feeling assured that they will not be disappointed in the results obtained.

### SOCIETY REPORTS.

#### OBSTETRICAL SOCIETY OF PHILADELPHIA.

*Thursday, March 7, 1889.*

The President, THEOPHILUS PARVIN, M.D., in the Chair.

DR. J. M. BALDY read a paper on

#### Complications Following Abdominal Section.<sup>1</sup>

DR. WILLIAM GOODELL, in opening the discussion, said he wholly agreed with the writer of the paper in regard to the stubborn nature of these fistulae and to the impossibility of avoiding them. He had now three cases of fistula. One followed the removal of an intraligamentary cyst, in which he had reopened the wound for bleeding. The patient recovered, but a fecal fistula had made its appearance about the fifth day after operation and had never closed. He had to peel off the tumor from the rectum. It was now a year and a half since the operation, and the patient was in the hands of a competent surgeon in the country. The only annoyance to her is an escape of gas from the wound. The second case followed the prolonged use of the drainage tube, after abdominal section for pelvic abscess. He had not had charge of the after treatment, but the patient was in the hands of a skilful surgeon. It may be needful yet to make a counter-opening in the vagina. The third case was one of recurrent intraligamentary cyst. The fist-

ula resulted from a previous operation, in which the surgeon used the clamp, many years ago. Dr. Goodell operated last November, and removed a recurrent cyst lying in a very large abscess cavity. A drainage tube was then used, which he still kept in, because he could not get the fistula to heal from the bottom. He had just made an application of iodine to the track, and told the husband to repeat it daily for a time. He has had cases of fistula when the drainage tube was not used, but they were due to non-encapsulation of the pedicle ligatures. In one while using the syringe the ligature was washed out. This gave him the cue, so in the others he fished the ligature out by means of a small hook on the end of a fine wire. On the other hand, in the case of an ovarian abscess, he had kept drainage up for several months, and yet the track closed. It is his intention in a third case to pass nitric acid to the bottom of the fistula, and see what can be accomplished in this way. In this case the patient menstruates through the track.

Dr. Goodell thought that if operators would wait some time after they have operated, before reporting their cases, they would find a number of hernias. He takes a good deal of pains to avoid this accident, and he closes the abdominal wound in an analogous way to that described by Dr. Price. The tendon when retracted he brings forward, as much as possible, with forceps, so as to bring it in contact with its fellow. He has had cases in spite of every care. In the official report of Imlach's cases, although these were all cases of oophorectomy, needing a very short incision, the percentage of hernias was fifteen. Dr. Goodell keeps his patients in bed for two weeks, before allowing them to sit up. In two cases in which he removed the ovaries, in fibroid tumors, he has had the incision rupture, from too early taking out of the stitches. In these cases he sometimes leaves them in for two weeks. One patient went home nineteen days after operation, in spite of orders, and the train becoming derailed, the jarring forced the cutaneous part of the wound open. Stitches had to be put in.

DR. M. PRICE does not think with Dr. Baldy that abdominal surgery has anything to regret in these cases. He admits that much of the dirt and filth and many of the accidents which follow these terrible operations are actually due to the surgeon. He does not wonder at there being fistulous tracks, for the reason that in many of these

<sup>1</sup>See REPORTER, page 420.

cases the adhesions to the bowel are of such strength that their separation often removes everything down to the mucous coat. He has seen as many as six or seven sutures applied to such a case. Fistula is a repetition of the old abscess, which finds its way to the surface through the drainage track. All of the disease has not been removed. In many cases the fistula saves the woman's life and gives the surgeon a path through which to perfect his otherwise imperfect work. Fistula is a proof that the case has not been properly cared for. He does not believe that thirty per cent., or even five per cent., represents the number of hernias. He has only seen two cases follow. Their closure is unattended with danger. If due care and cleanliness are observed, fistulae will not occur.

DR. J. PRICE was a little surprised that one so deeply interested as Dr. Baldy, in this subject of abdominal surgery, should stimulate criticism of our present position. Dr. Baldy speaks of hernia. The position of the incision, the condition of the abdominal walls, and the manner of introducing the sutures are of great importance. Death has followed tight sutures and he is satisfied that hernias often follow them. He always draws his sutures lightly. If three or four are used to the inch, tied lightly, with perfect coaptation, the results will, as a rule, be perfect. In introducing sutures he takes in half as much skin as fascia, and twice as much fascia as peritoneum. This gives better apposition to the centre of the wound. He has not had a suture-track abscess for more than a month, nor has there been any mischief about the tube. Nursing is of the greatest importance. The old nurses are meddlesome and dangerous, and he is glad to see them replaced by younger women. The tube can be dispensed with very often if the irrigation is thorough. Most surgeons are in too much of a hurry to get their patients up. Early rising is dangerous, and he has known surgeons to brag of getting their patients home in ten days.

In fistulous tracks, through which menstruation occurs, the only thing to do is to tie the tube and release it from the abdominal incision. A drainage tube resting against the torn bowel surfaces favors the occurrence of a fistula. A man who gets scared at a fistula or ventral hernia is not prepared to do good work; his work begins in doubt and ends in disaster. The operation for curing a ventral hernia is not dangerous.

We cannot ignore the importance of precision in diagnosis. We must try to decide as to the probable nature of the lesion. Dr. Baldy calls attention to one point, that is, the necessity of recognizing something definite on which to operate. Savage and others are satisfied to operate for subjective symptoms only. This is not right. The other day Dr. Price refused to operate on a patient who had multiple abscesses in the lungs. Two weeks before he had gone to the house prepared to operate, but the family had refused. The time will come when operators will be most arbitrary in these cases. We shall have the right to say that if the general practitioner waits until the eleventh hour we will not step in. Last summer a patient refused operation, to-day she sent for Dr. Price and requested it.

Peritonitis is often due to an imperfect toilet. It is often of limited extent or localized, leaving adhesions to portions of the viscera. This is a common source of pain and discomfort. The only good remedy is to do the work over and release the adhesions. This past summer he had either done himself, or assisted others to do, eight of these operations over, and they had been the most difficult and trying of his whole experience. He wished to call attention to one case on which he had operated three times. Dr. Baldy saw the work. When he first saw the patient pus was escaping from the umbilicus. He opened the abdomen, but failed to remove anything. Drainage was followed by a good recovery, but the wounds did not close. A year later he re-operated, but a fistulous track was left. Again a year later he used a catheter made of coils of wire. He passed this along around the ileo-pectenial line, toward the region of the kidney. He dissected along the pelvic bones and irrigated through the catheter. Last week, the patient was delivered of a fine baby. In this case he could find the ovaries, and there was no lesion of them or of the tubes. This is the only case of pelvic abscess without tubal disease he has ever seen, in a long and rich experience.

He wished to speak of two of the cases referred to by Dr. Baldy in his paper. One case he had operated on early in his experience, and had removed only one side of a specific tubal trouble. This he would never do again. The patient went into other hands, and he did not care to refer to the surgery which followed. Another case of which he had personal knowledge, was a case of imperfect surgery. This was a large pus sac, which could have been removed

but was drained. The woman died of psoas abscess. Skene has called attention in his book to the fact that pelvic abscess frequently causes psoas abscess. The incomplete removal of diseased tubes should be rectified. If an inch of tube is left it will most likely do mischief. He has curetted into the cavity of the uterus, removing a cone-shaped piece. The tubes should be tied hard on to the uterus, and the ovaries should be tied at a good surgical neck, and the results will be about perfect.

DR. MONTGOMERY said: We have become so enthusiastic in the field in which we are working as perhaps to overlook the dangers and difficulties, and in our desire to defend and possibly to push forward our own work, we sometimes fail to report our disasters. I think that Dr. Baldy has done us a kindness in dwelling on some of the disasters that may occur in abdominal operations. I am rather surprised to find that hernia is such a frequent lesion, in his experience. I have not found it so. The method of closing the wound suggested by Dr. Price, is the one that I have largely used, and unless Dr. Baldy has come across some case of which I do not know, I have never had a hernia in my experience. Fistulas with a constant discharge are exceedingly depressing and distressing. I have thought that drainage *per vaginam* might be preferable, where this accident is liable to occur. In such a case if fistula did follow, it would not be so bad as if it were in the abdomen. I operated last fall on a case in which half a gallon of broken-down blood was removed from a sac. The sac was drained, but death occurred in a few days. The *post-mortem* showed an abscess below the sac, which would have been opened if vaginal drainage had been performed. The after-treatment is exceedingly important in many cases. These results are no doubt due to the fact that there still remains some diseased tissue about the ligament or uterus. Where the tubal disease is gonorrhœal, it is very hard to tie close enough to the uterus to remove all the pyogenic membrane. Even when we do the inflammatory condition is still present in the uterus. The tendency of the extension of such inflammation to the pelvic tissues is in many cases the cause of after trouble.

DR. HIRST said that in three cases which he had lately to deal with, fistulae directly followed laparotomy. One woman died a year after the operation in consequence of this complication. In one case of great interest a mass of ligature was fished up, but

the fistula still remains. After waiting sometime he opened the vault of the vagina, behind the uterus, on the point of a sound passed into the fistula from above. He did not think he could have opened the bladder, but a vesical fistula must have already existed, for when he cut through the vault of the vagina, urine gushed out. A drainage tube was put through the whole track, but now four months have passed and the woman is dying. He would hardly think the use of nitric acid free from danger, used as recommended by Dr. Goodell.

DR. BALDY said: I did not bring these cases forward as an objection to abdominal surgery, nor would they, nor many more, stay my hand if I found a case which required operation. My desire was to call direct attention to such accidents as these and to stimulate our efforts to prevent their frequency. Nor is this by any means a complete list of all the cases on which I could put my hands. I could add dozens to the ones I have named. These cases have occurred in the hands of prominent men, men who profess to be teachers and who number their cases by the twenties, fifties and hundreds. If we see such accidents in the hands of such men, we shall have more serious results in the hands of those less expert. Many cases of fistula can be avoided by care in the use of the drainage tube. Few surgeons understand how to take care of a tube properly. I cannot agree with Dr. Price that fistulas always follow old fistulous tracks, and are caused by diseased tissue left behind. In the majority of cases that I have seen the diseased tissue has all been removed and the track occurs through what was formerly clean, healthy tissue. I think that one common cause of hernia is the use of haemostatic forceps. These bruise the tissues and if allowed to remain on too long cannot help irreparably damaging the vitality of the parts included between the blades. The less we use the forceps the better union we will get. It is a rare occurrence that I have to use more than one or two pairs, sometimes three. These are always removed in a few moments—in fact, as soon as I open the peritoneal cavity. They are no longer needed and often, if we are working through a small incision, are in the way. The fewer foreign bodies in and about the abdomen and abdominal wound, the better for the patient and the easier for the operator. Cleanliness in all its details cannot be too strongly insisted upon.

## NEW YORK ACADEMY OF MEDICINE.

*Stated Meeting, March 21, 1889.*

The President, ALFRED L. LOOMIS, M.D., in the Chair.

**The Place of Electricity in Therapeutics.**

The discussion on this subject was opened by DR. M. ALLEN STARR, the title of whose paper was,

**The Physics and Physiological Actions of Electricity.**

By electricity a new molecular state is produced in the body, but nothing is added to or subtracted from the body. Between the two poles this molecular change is more intense than elsewhere. He thought the term "current" responsible to a certain extent for the erroneous opinion prevailing regarding the action of electricity in therapeutics. The forms of electricity are frictional or static, voltaic or galvanic, and induced electricity or Faradism. He thought too much credence had been given to the therapeutic action of static electricity, for its effect is confined to the surface of the body, unless it acts reflexly; it is only mildly stimulating, and serves this purpose no better than massage or other mechanically acting stimulants. Besides, this object can be as well obtained by means of galvanism, which can also be used for permanently charging the body and in producing catalytic, cataphoric, and electrotonic effects. For disintegrating the bodily tissues galvanism has but a limited application in therapeutics. It is used for the removal of hairs, but gives place to other surgical procedures in the removal of tumors, etc. As to its use for stimulating nutrition, as in paresis of certain forms, he knew of but one scientific observation, that of Dr. Thatcher, in a case of paresis of the upper extremities, in which galvanism hastened recovery, while Faradism produced no such effect, and massage did actual harm. He has never seen a case of organic disease of the brain or spinal cord which he could consider cured by the application of electricity. Some cases improved under the treatment for a time, then grew worse, while others did not improve at all.

Regarding the power of reaching the deeper tissues, it is to be noted that the body is homogeneous, and that the power of conducting electricity in different tissues is variable. But little of the current reaches,

for instance, the brain or cord, in proportion to the amount applied to the surface. It is not impossible that favorable nutritive effects are produced by the increased circulation, and more rapid chemical changes brought about by the agent, as in lead palsy; yet he has not been able to convince himself of definite benefit attributable to this remedy alone.

There is no doubt of the power of electricity to promote osmosis, and this quality has been made use of in introducing drugs to allay pain.

Dr. Starr's conclusions were as follows:

1. Static electricity offers nothing more than the interrupted galvanic current, and fails to furnish those effects which are most desirable in the treatment of disease.
2. The constant galvanic current can produce chemical changes which aid nutrition or destroy tissue according to the strength employed.
3. The constant galvanic current can transfer medicines within the body from without.
4. The interrupted galvanic or Faradic current can excite various organs to functional activity.
5. It is questionable whether the pathological state causing organic diseases can be in any way influenced by electricity.
6. If functional diseases are benefited it is in an uncertain manner. The agent, therefore, is used empirically, and the physiological indications for it are as yet uncertain. As a therapeutic agent its use is somewhat limited, and a careful weighing in the balance is required to establish its sphere.

He concluded by saying that after the constant use of electricity during the past ten years he must acknowledge to disappointment in the results obtained.

DR. LANDON CARTER GRAY read a paper on

**The Effects of Electricity in Central Nervous Diseases.**

He first made some remarks suggested by Dr. Starr's paper, and said that he would undertake as positively to obtain certain therapeutic effects from electricity in certain neuralgias and neurasthenic cases as he would from opium in other diseases. He did not claim, however, to cure the organic disease, and no more could be said of any drug in the Pharmacopoeia. A great deal depends upon the way in which electricity is used. Electricity is useful in the functional insanities only in the period of convalescence. It is not considered in chronic and incurable forms. It is also beneficial in certain of the gross diseases of the brain, as in the early stage of cerebral syphilis, before hemiplegia

proportionate surface. nutritive and circulatory changes in lead convince one to this of electric quality drugs follows: more than 1 fails to desirably the con- chemical by tissue 3. The other medi- 4. The agent can patho- cally. patho- can be 6. If s in an before, is al indica- As a imited, nce is ter the past appoint- a paper central

ted by would certain certain would not disease, rug in depends. insani- ce. It durable of the early plegia

supervened. Meningitis of traumatic origin, producing hemiplegia, if slight, may be benefited by electricity, and if hemiplegia of vascular origin is not followed by contracture it can also usually be thus benefited. *Tic douloureux* is uncertain in its response to electricity.

The two currents which will answer every purpose of the physician are the galvanic and Faradic. The administration of electricity in diseases of the brain consists of cerebral galvanization and peripheral Faradization. Regarding the choice of poles, he could lay down no other rule than this: where one pole does not agree, try the other; and if that does not agree, stop using electricity. The question of the ascending and descending current has of late years been merged into the question of poles; although he thinks there is a difference, he knows no indication for one more than for the other. He said this in spite of the indubitable differences chemically, physiologically, and pathologically between the negative and the positive pole.

DR. W. R. BIRDSALL discussed

### The Effect of Electricity in Spinal Cord Diseases.

He thought much of the disappointment of some persons in the employment of electricity is that they have anticipated too much of it. He agrees with Dr. Starr, that he has never seen it cure a case of organic disease of the spinal cord, but then he has never seen any other single remedy do this. Electricity, however, is beneficial in relieving certain symptoms attending these affections, as pain, anesthesia, spasm, paresis, trophic changes. He regards its action as essentially stimulant, an excitor of living tissues.

DR. A. D. ROCKWELL read a paper on

### Effects of Electricity in Peripheral Nerve Lesions.

He has found the agent beneficial in several of the neuralgias, especially facial paralysis, in which the form of current to be used depends upon whether the intramuscular nerves have at the outset become completely paralyzed for the time being. If so, Faradic electricity, which exerts its influence chiefly upon them, would produce no response, while galvanic electricity would produce contraction because it influences principally the muscle fibre which is still intact. Electricity is useful in diphtheritic paralysis.

DR. E. D. FISHER read a paper on  
The Effects of Electricity in Functional Nerve Affections.

In the course of his remarks he said he would not discard static electricity quite so positively as it would seem Dr. Starr would do. He thought it had its uses in neurasthenic cases and in those functional affections characterized by errors in nutrition.

DR. PUTNAM JACOBI summed up the statistics of uterine fibromata treated by electricity. They were, not very extensive nor very definite. Those who had reported their experience with it had often seen relief from symptoms, and some diminution in the size of the tumor.

DR. GEORGE W. JACOBY took much the same view of electricity as a therapeutic agent as Dr. Starr had done. The agent being used empirically, had been resorted to in every disease and symptom imaginable. Very frequently benefit was reported in cases which it is likely would have recovered without the electricity.

DR. LEOPOLD PUTZELL also thought those who attributed good results to electricity often overlooked the natural course of the disease. In facial paralysis, and diphtheritic paralysis, which had been referred to by Dr. Rockwell, this statement is true. The Faradic current applied with the brush over painful points in neuralgia often has a rapid effect. In one case varicose veins of the leg of twenty years' duration practically disappeared under Faradism.

DR. J. H. GIRDNER had been experimenting to determine the electrical state of the human body in health and disease. Putting one pole in the mouth and the other in the rectum, a considerable difference in the electrical state was found under varying conditions. The variations were especially great between health and disease. This is not to be attributed to the fluid at the pole.

DR. PETERSON said he had lately been employing electricity in introducing a mixture of cocaine and aconite under the skin and at painful neuralgic points. He has thus been able to quiet pain for from five to eleven hours.

DR. WILLIAM H. THOMPSON distinguished between the influence of galvanic and Faradic electricity, and said that he had obtained much benefit from the latter in stimulating the arterial circulation of parts and thus overcoming paresis, and causing absorption of exudates in subacute affections, as articular rheumatism, pleurisy with effusion, etc.

DR. ANDREW H. SMITH has found quicker and more positive benefit from static electricity than from any other form in stiffness and soreness of parts due to exposure to cold, as in stiffness of the hand and wrist of stage drivers, etc. He thought the electrical variations observed by Dr. Girdner were to be attributed to substances accidentally present in the body.

DR. STARR, in closing the discussion, said, respecting the action of Faradism being directed more especially to the intramuscular nerves and galvanism to the muscular fibres, that there is no truth in this statement. The reason why Faradism does not produce a response is that the interruptions are too rapid. Make them slowly and the muscle will respond to it as well as to galvanism. He said the discussion had confirmed him in his view that electricity is of limited value in therapeutics.

## REPORTS OF CLINICS.

### PHILADELPHIA HOSPITAL.

#### CLINIC UPON OBSTETRICS, AND DISEASES OF CHILDREN—DR. PARVIN.

##### Death of an Infant from Hemorrhage from the Mouth.

Dr. Parvin first spoke of the death of an infant from hemorrhage from the mouth, a few hours after birth, and said: A most unusual case recently occurred in the Maternity. A woman was in labor, the presentation being pelvic; after the delivery of the body, and after the face had rotated posteriorly, the resident physician, anxious to keep the head well flexed and also thus facilitate delivery by traction, pressed upon the lower jaw with one or two fingers partly introduced into the mouth; the child was delivered living, but a short time after birth the nurse observed blood oozing from the mouth. Upon examination there was found blood coming from just beneath the tongue on one side. Various means to arrest the flow were tried, but they were unsuccessful, and the child died. It has been supposed that this child was a "bleeder," that is, suffered from hemophilia. The bleeding, whether traumatic or spontaneous in such a subject, is rebellious to remedies; such was the fact in this case, and so, reversing the familiar statement that the cure proves the disease, we might say the failure to cure may also prove the disease.

The point, however, to which I desire to call your special attention is as to the management of head-last labors with reference to assisting flexion and hastening delivery, when posterior rotation of the face has occurred after the expulsion of the body. The method most generally recommended is that known by the compound name Smellie-Veit. Two fingers of one hand are introduced into the mouth, care being taken to press only upon the alveolar processes of the lower jaw; at the same time two fingers of the other hand are passed over the nape of the neck; traction is now made, chiefly with the fingers pressing upon the lower jaw. But may we not produce safer and equally effectual pressure with two fingers upon the superior maxillary, while two fingers of the other hand press up the occiput, and thus secure the prompt expulsion of the mental end of the occipito-mental diameter?

Of course, a prompt delivery is imperatively necessary when this stage of labor is reached, for the child is liable to perish from asphyxia, the chief source of such asphyxia being pressure upon the cord, assisted by partial detachment or very great compression of the placenta when the uterus is so nearly completely emptied, provided its normal retraction has occurred. I cannot but think that pelvic deliveries are more liable to be attended by intra-cranial injuries, which, though not always mortal, may have a very injurious effect upon the child's condition. Crueilhier has stated that of the children perishing in labor, one-third die from cerebral hemorrhage. In recently looking over some statistics of convulsions or of paralyses following labor, and of defective mental development, I was struck with the relatively greater number of these unfortunates that had been born by a pelvic presentation, or after podalic version had been performed. If this be true the explanation probably is found in the necessarily rapid passing of the head, before time can be given for its molding, through the bony pelvis, and hence injurious compression made with consequent intra-cranial hemorrhage. The head must be delivered quickly, or the child dies: but this delivery may be secured by the sacrifice of the child's health—it comes into the world possibly to live only a few days, months or years, but at best living an imperfect, incomplete life.

##### Intra-Cranial Hemorrhage.

Seventy-two hours after its birth an infant in the Maternity was attacked with convul-

sions, and in twelve hours died. The autopsy revealed a hemorrhagic clot upon the right side under the dura mater. There was no external injury, and the labor had ended spontaneously and was not long. I mention this case to show you an example of intra-cranial hemorrhage caused by natural labor. The rule is that, if the effusion of blood be considerable, death takes place within twenty-four hours. The fact that this child lived so long before symptoms occurred and then for twelve hours afterward, shows that the rule must not be regarded as absolute. Where a diagnosis of hemorrhagic effusion has been made, it has been proposed to aspirate; but it seems to me that this would be very uncertain treatment, for it could not remove a clot, nor could it furnish any guarantee against a fresh effusion.

#### Induction of Premature Labor in Contraction of the Pelvic Inlet.

The measurements that have been previously taken, and which have now been again taken before you in order to give you an illustration of pelvimetry, prove that this woman, who is in her eighth month of pregnancy, has a pelvis of which the true conjugate is somewhat under four inches. You know that in the mechanism of labor in the simple flat pelvis, the foetal head passes through the inlet with its biparietal diameter in relation with the true conjugate. When once the head has made this passage, cleared this strait, there is no more trouble in the labor. Now although in this woman, supposing the bi-parietal of the child's head at term to be three inches and a half, the true conjugate exceeds it by a small fraction of an inch; and although the former diameter may be reduced one centimeter, or about two-fifths of an inch, and therefore labor at nine months would probably be difficult, yet it is also probable that the woman could deliver herself, and it is possible her child might be born living, and without any intra-cranial injury such as has been referred to. It would nevertheless be safer to induce premature labor early in the ninth month. Bearing in mind that the increase of the biparietal diameter in the latter months of pregnancy is one centimeter a month, you determine, after having ascertained the degree of pelvic contraction, the time for the induction of premature labor, endeavoring to delay this as long as is safe for mother and child, so that the latter may have the best chance of living

after delivery. Many a child born prematurely perishes, but I confess I was somewhat startled by reading in Winckel's recent work upon obstetrics that the foetal mortality after the induction of premature labor is 66.6 per cent.

The question as to the means of inducing premature labor may be asked. That method which most obstetricians employ is the one known as Krause's, that is, by the introduction of an elastic bougie between the ovum and the uterine wall. Quite recently I was reading in a French journal the history of a case in which such introduction, though attempted by an able hand, was impossible; the difficulty arose from a very marked anteflexion of the uterus: the operator then succeeded in bringing on labor by the use of tents.

Of course all antiseptic precautions must be used in this operation; the bougie must be clean, and dipped in an antiseptic solution—for example, in a solution consisting of 1 part of corrosive sublimate to 1000 of water; the vagina must be thoroughly cleansed with an antiseptic solution. The operator's hand, after careful and complete washing, must also be put in a similar fluid. Then the bougie is carefully passed into the uterus, made to feel its way, insinuate itself between the ovum and the uterine wall, always moving it in the direction of the least resistance, until it is quite within the uterus. Labor in the majority of cases begins within twenty-four hours; but in some it may be delayed for days. What is to be done in the latter case? Repeat the application of the bougie, only at each new introduction give the instrument a different direction from any that it previously had.

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#### COLLEGE OF PHYSICIANS AND SURGEONS—VANDERBILT CLINIC.

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#### CLINIC FOR GENITO-URINARY DISEASES— PROF. OTIS.

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#### Gonorrhœa.

In the previous lecture Dr. Otis discussed acute gonorrhœa, but he said it would be improper to dismiss the subject without reference to those long-standing cases of acute gonorrhœa in which the inflammation is not confined, as usual, to the anterior part of the urethra, but extends to the membranous portion, and beyond; sometimes involving the bladder, ureters, and even the kidneys. The causes which tend to produce this condition are excessive exercise, bad living, alcoholic

indulgence and, most decidedly, sexual indulgence, both in act and thought.

The first symptom that will call attention to the disease is frequent urination, which is a sign usually that the neck of the bladder is involved. For relief of this, rest is most important, together with suppositories of opium or enemata of hot water. It is most essential that the sound and catheter be not used during this stage. Even should there be retention of urine it is advisable first to employ other means of relief than the catheter, such as hot baths, hot enemata, and 5 to 10 drop doses of the muriated tincture of iron, every hour, in the hope of thus relieving the retention.

In cases of involvement of the deeper urethra there is danger when using instruments of pushing the contagion further on. But when the bladder is once involved there is no longer necessity for avoiding the use of catheters.

The treatment of the condition under consideration is by the injection of a few drops of a solution of nitrate of silver, 3 to 5 grains to the ounce, directly upon the membranous urethra. It is also one of the most reliable means of curing a beginning cystitis.

*Chronic gonorrhœa* is due to the fact that on the diseased spots the epithelium is not replaced because of the plastic material beneath. When endoscopy first came into employment it was supposed that its value would be very great, that these spots could then be exactly located and applications made directly upon them. But even after this treatment and after the patient had been discharged apparently cured, it was found that very frequently he came back, perhaps months afterward, complaining of a return of his discharge. In reality a stricture is at the bottom of most of these cases, and it is only when this is removed that we can expect a permanent good from the applications. Often the cure of the stricture will stop the discharge.

*Case I.*—The patient was a man 30 years old, who presented himself with chronic gonorrhœa. He has several strictures which will not now be located. By the endoscope we see evidences of these as well as patches of inflammation. The treatment now recommended in such a case as this would be the irrigation of the urethra after the following method. A syringe, holding several ounces of a medicated solution, is attached to a catheter and the catheter is passed down to the membranous urethra, not into the bladder. The syringe is slowly emptied through the catheter, the fluid passing along the deep

urethra into the bladder. The apparatus is withdrawn and the patient voids the injection, thus medicating the entire canal. The following solutions are recommended:

No. 1 Acidi Carbolic, Zinc Sulphatis,  
Alumenis . . . . . aa 1 part  
Aqua . . . . . 1500 parts  
at first; then 1000; then 500 parts

No. 2 Potass. Permanganat. . . . . 1 part  
Aqua . . . . . 1000 parts

No. 3 Argenti Nitrat. . . . . 1 part  
Aqua Destil. . . . . 1000 parts

To this method there is only one objection, namely, it may set up a prostatitis; this is clearly due to the impact of the fluid against the prostatic urethra. The same complication sometimes occurs after the passage of a sound. It is an objectionable occurrence as it is liable to be persistent, not infrequently lasting a year or more; and being evidently due to the measures used by the physician he is pretty sure to be credited with it. So that although Prof. Otis has had most excellent results, especially from injection No. 1, employed in this manner in chronic urethritis, and also in cystitis, his advice would be not to use this procedure, but rather the ordinary syringe employed in the usual way. He decidedly advises against the use of a sound in these cases, previous to the large injection, for the purpose of ironing out the mucous membrane.

After the employment of these or similar injections, in many instances, the discharge continues. Then the endoscope may be used. But after all, though this instrument is of undoubted utility it is not a necessity. We can locate the diseased and tender areas as well with a bulbous sound, and in this manner as accurately apply our nitrate of silver as through the endoscope.

#### Stone in the Bladder.

*Case II.*—The patient was a man, 55 years old. For two years he has had trouble in urinating, micturition being frequent and but little urine passing at a time. He has had pain at the end of the penis. The urine has never stopped suddenly while being voided. This last is a valuable symptom, but it is well to remember that this and all symptoms may be frequently absent. Dr. Otis recalls a case in which a very large stone existed for many years without any symptom of bladder trouble.

In examining this man he first elevated the hips so that the stone fell to the upper part of the bladder. Passing in the

sound he found a calculus, and applying the Billroth audiphone the click of the sound against the stone was heard 30 feet away. It was a large stone. If it had been found small, by measurement, it might have been crushed before the class, but he does not like to operate in such a case as this unless he is able to put the patient at once to bed. In this man there is some narrowing of the urethral canal as well as considerable spasm. The physician should always attend first to the determination of the condition of the urethra. Then before operating, he should make due preparation, by making the urethra large enough to facilitate the main operation.

The difficulties in litholapaxy are not from injuries to the bladder, but from irritation to the urethra. This point Dr. Otis was the first to make in 1881, and he believes it now fully proved by *post-mortem* evidence.

### PERISCOPE.

#### To Avoid Corrosive Sublimate Poisoning.

In a communication to the *Amer. Journal of Obstetrics*, Feb., 1889, on the Puerperal Uterus, Drs. F. L. and John R. Haynes give the following advice:

1. Where intra-uterine irrigation is used in the absence of sepsis, use no sublimate, but plain hot water, or salt and water.

2. If the urine is albuminous and scanty, use no mercury.

3. If the urine is slightly albuminous and copious, or if the patient is profoundly anemic, do not use more than a pint of a solution of 1 : 8,000.

4. Always use tartaric acid and sublimate tablets or powders; dissolve thoroughly in a small quantity of water and mix carefully with a definite quantity of hot water in a pitcher, from which pour into the irrigator.

5. Always use a fountain syringe, and for the uterus a double tube, so as to insure the return of the solution. If for any reason the fluid fails to run out as fast as it flows in (if not through the reflux tube, by way of the channels at its sides), shut off the flow. The irrigator should not be raised more than three feet.

6. Precede by copious irrigation with hot water to wash out blood, etc., which may form with sublimate adhesive albuminous compounds, which may in time be absorbed. Follow by a quart or two of hot water to insure the evacuation of all the sublimate solution.

7. For the uterus, use a solution not stronger than 1 : 8,000 and not more than a quart, once daily.

8. For the vagina, use a solution not stronger than 1 : 4,000 and not more than a quart, twice daily.

Irrigation used in the above way is, they believe, a practice almost devoid of danger. They have made more than one hundred and seventy-five irrigations with the double tube and fountain syringe, with no untoward results, except in two cases an unimportant rise of temperature, and in one a severe but harmless chill; and even these slight accidents they are certain might have been avoided by greater care. Nevertheless they assert that irrigation of the puerperal uterus will always be a procedure requiring great care and judgment and some skill. They agree with Credé and Fehling, that both vaginal and uterine irrigations are attended with undoubted dangers, and should never be employed in the puerperal state unless to meet definite indications.

#### Chloroform Administration.

At the distribution of the prizes to the students of the Hyderabad Medical School, by their Royal Highnesses the Duke and Duchess of Connaught, on January 25, Surgeon-Major Lawrie, M.D., Principal of the Medical School, in a short address, referred to the commission appointed last year by the Nizam's Government, to make experiments with reference to the effects of chloroform. Dr. Lawrie said the experiments which had been carried out by the commission, consisting of Dr. Hehir, Mr. Kelly and Mr. Chamarette, were, in his opinion, the most important that had ever been made, and had conclusively decided a question which had been in dispute ever since chloroform was first introduced. There is no doubt, he said, that the anaesthesia produced by chloroform is best measured by its effect on the breathing, and that when the administration is pushed beyond a safe point, the breathing becomes embarrassed and then stops. The question in dispute is whether chloroform ever affects the heart directly or not; and this is important in its bearing on the way in which the administration of the anaesthetic should be conducted.

The following was the work performed by the commission, as described by Dr. Lawrie. They killed with chloroform 128 full-grown pariah dogs, averaging over twenty pounds weight each. This does not represent a tithe of the experiments they actually performed, which really amounted to several

hundreds, as they varied the dose and the method of administering the chloroform in every possible way, and tested the value of artificial respiration in nearly every case by reviving the dogs over and over again after the breathing had stopped, and before the heart ceased beating. What they found was, that no matter in what way it was given, in no case did the heart become dangerously affected by chloroform until after the breathing had stopped. "This," adds Dr. Lawrie, "tallies exactly with my own experience. I have given chloroform as often, or oftener, than any man living, and have never had a fatal case; and I can state positively that in the 40,000 or 50,000 administrations I have superintended I have never seen the heart injuriously or dangerously affected by it. I take no credit to myself in this matter. I have simply carried out in India the principles Simpson and Syme practised and taught in Edinburgh." In the hospitals attached to their school, chloroform was invariably given with absolute, or with almost guaranteed safety, by students, and they were never allowed to examine the heart beforehand, or feel the pulse during its administration. In other places, and in London itself, deaths from chloroform constantly occur, but provided the administrator could swear he examined the heart and felt the pulse, they were always supposed to be accidental. Dr. Lawrie has no doubt deaths will go on occurring until the London schools, which of course influence the whole world, either entirely change their principles and ignore the heart in chloroform administration, or else confine themselves exclusively to the use of an anæsthetic like ether, which, with all its disadvantages, they know how to manage.—*British Med. Journal*, Feb. 23, 1889.

#### How to Preserve the Hands.

Dr. George Meyer, of Berlin, in a paper published in the *Berliner klin. Wochenschrift*, Jan. 14, 1889, says that in using the different methods of disinfection for the hands, which are at present considered necessary, the skin is always more or less affected. Reddening, eczema, and cracks of the skin are often the results of repeated washings and scrubbings with antiseptic materials, so that at times entire abstinence from the use of disinfecting fluids seems necessary. Fluid antiseptics contribute especially to roughening the skin of the hands, which results in the skin becoming cracked when the hands are subsequently exposed to the cold air and are not sufficiently dry.

There have been several methods, Dr. Meyer says, which have been proposed to keep the skin of the hands, especially physicians' hands, soft and pliable. He then speaks of a method recommended to him by Professor Liebreich, which is very easy to carry out. It has been of more use to him than all other formulas during the years that he suffered with red hands. It has nothing to do with the disinfection of the hands, but merely serves to keep their skin in a normal condition. His own hands, which for years were red and tender, have since its use become nearly normal in color. Moreover, he says he can use it with all disinfectants, without having to fear any further effects on the hands, since its use renders the skin smooth and soft.

After thoroughly washing the hands with a soap that makes a lather easily, they are well wiped and thoroughly dried; then the hands, especially the one most exposed to infection in the daily intercourse of life, is rubbed with a little lanolin, and any excess removed with a handkerchief. Other substances may be added to the lanolin, according to preference; Dr. Meyer uses the following:

R Lanolin Puriss.	98 parts.
Extract. Vanill.	2 parts.
Olei Roseæ	git. j.

This, he says, is a salve for the skin which he has always found satisfactory. It has been shown that a smoother salve can also be made by the following formula:

R Lanolin	79 parts.
Liquid Paraffin	19 parts.
Extract. Vanillæ	2 parts.
Olei Roseæ	git. j.
M. et ft. terendo unguent.	

For applying away from home the lanolin may be carried in small metal collapsible tubes. The ointment is to be reapplied after every washing, and each time in such a way that the lanolin will be thoroughly rubbed into the skin. This is especially recommended during the winter. In speaking of the favorable effect of lanolin, he mentions its power of mixing with water, by virtue of which, after washing the hands, any water remaining on the skin from imperfect wiping is absorbed by the lanolin, and the hands prepared for the cold with the least possible grease. By these two latter qualities the hands are prevented from cracking and reddening.

In practice he has used the method with good result for rubbing on the face, as in actors, whose skin had suffered from the use of paint.

THE  
**MEDICAL AND SURGICAL  
 REPORTER.**  
 ISSUED EVERY SATURDAY.

CHARLES W. DULLES, M.D.,  
 EDITOR AND PUBLISHER.

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NEVER ROLL A MANUSCRIPT! Try to get an envelope or  
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The Editor will be glad to get medical news, but it is  
 important that brevity and actual interest shall characterize  
 communications intended for publication.

**PALPATION OF THE KIDNEYS.**

It is a curious fact that, within the last few weeks and almost simultaneously, two distinguished clinicians of Europe have published important communications in regard to palpation of the kidneys for diagnostic purposes. Both Guyon, in Paris, and Israel, in Berlin have recently cited their observations and experiences to show that the kidneys are not so inaccessible to touch as is commonly supposed. The former has described his methods of investigation in a lecture at the Hôpital Necker, reported in the *Gazette Hebdomadaire*, Feb. 8, 1889,

with great clearness and instructiveness, while Israel has published a very valuable article on the subject, in the *Berliner klinische Wochenschrift*, February 18, 1889.

Progress in treating diseased kidneys is now needed, as Israel states, more in the direction of finer methods of diagnosis than in that of the technique of surgical operations. The kidneys are situated upon the posterior wall of the abdominal cavity, upon the lowest dorsal and the three upper lumbar vertebrae. Their upper half is covered by the wall of the thorax, their lower half only by soft parts. Their diameter from hilus to convexity is directed obliquely, with the hilus presenting in front and toward the middle line. Their long axis is also obliquely placed, being nearer the spinal column above than it is below. The right kidney is placed at a slightly higher level than the left. If a line be drawn from the middle of Poupart's ligament, parallel to the linea alba, and a perpendicular be let fall from it two fingers' breadth below the point where it meets the lower border of the ribs, the perpendicular will meet the normal kidney. As Israel says, a correct understanding of these simple anatomical facts is of the greatest moment in examining the kidneys.

To utilize them certain favoring conditions are essential. The abdominal fat must not be too extensive, and the tension of the parietes must not be too great. To facilitate an examination, the bowels must always be emptied, and chloroform may be administered to relax the muscles of the abdomen, although anesthesia interferes with voluntary deep inspiration, which is often of great assistance. Emptying the bowels not only diminishes their tension, but also removes the risk of mistaking fecal accumulations for the kidneys.

The best methods of examining the kidneys are these. First, by deep pressure with the fingers, gently and yet steadily following up the slight gain which can be made

with each profound inspiration and expiration, taking care not to mistake any part of the liver or the spleen for the kidney. Second, by what Guyon calls *ballotement rénal*, which is effected by combining the first method with short taps or thrusts made with the fingers pressed firmly against the back, over the region of the kidney, by means of which it is propelled against the fingers pressing down in front. The third method is recommended by Israel, and consists in placing the patient on the side, with the knees and thighs slightly flexed, and making bimanual pressure very similar to that described by Guyon for *ballotement*.

A fourth method has been proposed by Glénard, of Lyons, which consists simply in palpating the region of the kidney between the thumb in front and the fingers of the same hand pressed up in the costo-vertebral angle.

In conducting these examinations all investigators agree that the rhythmic motion of the kidney with each inspiration can be detected, and alteration of its position, size, shape, consistency and sensibility. The detection of rhythmical motion in the kidney is a point in these examinations which it is important not to overlook, especially as the general supposition has been that the kidneys are immovable, and that motion in rhythm with the respiratory act serves to differentiate tumors connected with the intra-abdominal organs from those connected with or in the kidneys.

We cannot spare space at this time to point out all the valuable information in regard to the kidneys which may be gained by a successful palpation, as described above. But one extremely important point deserves mention. This is that, in any contemplated operation on the kidney, it must always be of great value to ascertain if the other kidney is present, and of probably normal size. Another point, which Israel has found extremely useful in practice, is that an erroneous diagnosis of floating kidney may

sometimes be corrected, and a useless operation avoided by finding the kidneys where they ought to be.

In conclusion, it may be noted that this valuable method of diagnosis is not practicable in every case, and that it should always be associated with every other known method of ascertaining the physical and functional condition of the kidneys. But, with this well understood, the methods we have described constitute a very valuable addition to our means of examining the kidneys, and one which deserves the widest dissemination among medical men.

#### FUNCTION OF THE COCCYX IN LABOR.

It is quite impossible to over-estimate the importance of thoroughly understanding the mechanism of the passage of the foetus through the pelvis. This dominates the whole scientific practice of midwifery, and the practitioner cannot acquire more than a merely empirical knowledge, such as may be possessed by an uneducated midwife, or conduct the more difficult cases requiring operative interference, with safety to the patient or satisfaction to himself, unless he thoroughly masters the subject.

Thus appreciating a knowledge of the mechanism of labor, we have read with much pleasure a contribution to the study of the subject by Dr. Henry D. Fry, of Washington, entitled "The Function of the Coccyx in the Mechanism of Labor" (*Amer. Journal of Obstetrics*, Dec., 1888). Dr. Fry states that obstetricians in general attribute no function whatever to this little bone, except to get out of the way of the advancing head, and thereby to increase the antero-posterior diameter of the inferior strait. It is not even supposed to possess any obstetrical importance unless it rudely refuses to be pushed aside. He believes, however, that the coccyx has a distinct function to perform and that only after it has performed it does the bone recede before the advancing head. According to Dr. Fry, the function of the coccyx in labor is to cause extreme flexion

of the head—in anterior positions of the vertex—at the inferior strait, whereby the escape of the occiput from beneath the pubic arch is facilitated, and the sub-occipito-bregmatic diameter of the head is brought in relation with the antero-posterior diameter of the pelvis, instead of the longer occipito-frontal, or occipito-bregmatic diameter. When the head reaches the inferior strait in normal labor it is not in extreme flexion. But as the head advances the brow meets with the resistance of the coccyx, its advance is arrested and the occiput descends. The resistance of the coccyx keeps up flexion until the occiput escapes from beneath the pubic arch and the nape of the neck becomes fixed against the symphysis pubis, when, since the occiput can advance no further, the force of the expulsive efforts is transmitted to the brow, overcoming the resistance of the coccyx and causing extension of the head with delivery of the brow and face.

While these views of Dr. Fry seem to be but a slight modification of the view that this last exaggerated flexion of the head is brought about by the resistance of the pelvic floor against the advance of the frontal region of the head—because the resistance of the normal coccyx must be equal to the resistance of its muscles—yet it is well to have the fact insisted upon that exaggerated flexion of the head does occur during the escape of the occiput, and prior to extension of the head. Because, while usually admitted, its bearing upon the proper management of the close of the second stage of labor is not generally appreciated. Having in mind the mechanism of passage of the head through the inferior strait and soft parts, the practitioner is enabled intelligently to manage this stage of labor, favoring flexion or extension of the head, and retarding or accelerating its advance by his manipulations as the circumstances indicate, all being done in accordance with, instead of in opposition to, the natural mechanism of labor.

#### HYSTERIA IN CHILDREN.

Typical examples of common diseases are easily and quickly recognized by general practitioners. It is in the diagnosis of rare diseases and of unusual manifestations of common diseases that mistakes are frequent. Thus a pneumonia of the apex has been mistaken for meningitis, and alcoholic delirium has been taken for acute mania. Such errors are often the result of carelessness rather than of ignorance; but it is at all times difficult, even for a well-read man, to keep such a comprehensive picture of a disease before his mind that he can at once recognize it, no matter how it may be obscured by unusual phenomena. This difficulty is increased when the disease in question is hysteria, in which the possible manifestations are limited only by the range of intelligence and degree of moral depravity of the patient.

Some of our readers may recollect a lecture by Charcot on Hysteria and Spiritism, which was published in the REPORTER, July 21 and August 25, 1888, and in which Charcot related in detail the histories of three children living in a penitentiary and developing hysteria under the influence of certain spiritistic exhibitions indulged in by their parents and others. There were three children, two boys and a girl. Hysteria developed in the latter in August, 1884, following a *séance* of spiritualism, in which the girl played the part of medium. At the end of the *séance* she was taken with convulsions, which were repeated from fifteen to twenty times a day, until both brothers followed the deplorable example set by their sister and developed fits of delirium associated with hallucinations.

Instances of hysteria in children, more or less similar to the one just quoted from Charcot, are not unknown in this country; but unfortunately they frequently fall under the notice of those who are unable to recognize the disease and who, perhaps, are ignorant of the fact that it may occur among children. What is perhaps a curious illus-

tration of the statement just made may be found in the report, which comes from one of the Western States, that three children in one family, ranging from six to twelve years of age, were suddenly seized with "violent paroxysms," in which "they raved like maniacs and frothed at the mouth as if afflicted with hydrophobia." It is further stated that the children had to be locked in separate rooms and that at regular intervals they went into violent convulsions, which were so severe that two or three persons were required to restrain the patients.

These symptoms may or may not have been due to hysteria, but the fact that they developed suddenly and without apparent cause in three members of one family, and that the paroxysms were alike in each and occurred at the same hour each day, is strongly suggestive of hysteria. At least hysteria is the disease first to be thought of when the symptoms mentioned as occurring in these children appear, and the diagnosis of a more serious affection should not be made until the milder one has been excluded by careful examination. The important point, after all, is—not to know whether this or that instance of sudden explosion of nervous energy is due to hysteria or not, but rather to bear in mind the possibility that it may be, and to be able to recognize it when it is.

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that abscess comes next in frequency; that sarcoma occupies the third place; and that lymphoma and lymphadenomata come next, though they are much more rare than the other forms of disease named.

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the physician who had attended her in the miscarriage had seen and examined the fetus and afterbirth and assured her that everything had come away, and that she might go about as she pleased, after the ninth day.

I packed the vagina with carbolized absorbent cotton, and gave, every three hours, suppositories containing ten grains of ergotin and a quarter of a grain of extract of opium. This treatment I continued for five days, being careful to remove the tampon and give a vaginal injection of a solution of corrosive sublimate—one to two thousand—every twenty-four hours. On the sixth day I dilated the cervix with dilators and removed the entire placenta—curetting the uterine cavity and washing it with a solution of bichloride of mercury. There was at no time any offensive discharge, and the patient had no pain and no fever. In two weeks after the operation she returned to her home in Atlantic City in good health.

Yours truly,  
C. H. SHIVERS, M.D.

Haddonfield, N. J.,  
March 5, 1889.

## NOTES AND COMMENTS.

### A Native Indian Doctor.

One of the recent graduates of the Woman's Medical College of Pennsylvania is a native Indian, Dr. Susan La Flesche, of whom Dr. Walker, in his address to the graduates, gave some interesting information. It seems that she commenced her studies of English at the school on the Indian reservation. Coming East, she continued them for a while at a boarding-school, and later at the Indian school at Hampton, Va., where she graduated in 1886, and then came at once to Philadelphia to study medicine. The impulse to a professional career was the result of a desire to see her people independent of the unskilled, and oftener indifferent, attention of the reservation doctor.

### Anatomy of the Contortionist.

Dr. Thomas Dwight, in an article in *Scribner's Magazine*, April, 1889, says: What, then, is a contortionist? In the first place, it appears that a contortionist is a person who has preserved in his spine, and in some cases in his joints, the infantile condition which in most persons is merely transient. This implies a great flexibility

of the spine in all directions, great powers of twisting it. It is also very likely that there are many small individual peculiarities all favoring uncommon freedom of motion. If a young boy without any of this special fitness should be trained for contortion, I think he probably would meet with some success, but never achieve distinction. So far as I am aware, children are not educated for this profession from their tenderest years, as they are for several kinds of acrobatic performances. Their capacity makes itself known by accident, from which it is fair to infer that it rests on an anatomical basis.

### A Fight at the New York Maternity Hospital.

The Faculty of the College of Physicians and Surgeons of New York is investigating an exchange of blows which took place March 22, between the house physician of the Sloane Maternity Hospital and a student at the College of Physicians and Surgeons.

According to the statement of the latter and his friends, one day last week a patient was being attended by the house physician, when she clutched his arm. For this she was dealt a blow on the face. The student in question, who was standing by at the time, indignantly resented this treatment. A few days subsequently the house physician and the student met at the Maternity, and it is alleged that the former began the attack, which resulted in his getting a severe thrashing. The committee which has charge of the investigation will conclude its labors soon.

### Convention for the Revision and Publication of the Pharmacopoeia of the United States.

A call for a General Convention for the revision and publication of the United States Pharmacopoeia, to assemble in Washington, D. C., at noon of May 7, 1890, has been issued by Robert Amory, President of the Convention of 1880. It is requested that every incorporated medical or pharmaceutical College, Association or Society desiring to be represented in the Convention send to Mr. Amory its corporate title and a list of its officers, addressed to the care of Dr. Edwin H. Brigham, Assistant Librarian of the Boston Medical Library, 19 Boylston Place, Boston, Mass., in order that Mr. Amory may prepare for publication, as directed by the Convention of 1880, a list of the bodies to be represented.

**The Governor of Illinois on the Medical Practice Act.**

In his message of January 9 to the General Assembly of Illinois, Governor Oglesby discussed the Medical Practice Act as follows :

During less than twelve years of its existence, this act has done much to protect the sick and the afflicted from charlatans and quacks ; it has driven out of the State most of the ignorant, unqualified and unprincipled men who were preying upon the miseries of their fellows ; and it is not too much to say that it has elevated and ennobled the practice of medicine, both in the State and throughout the country. The methods of medical education have been improved as a consequence, and the standard of attainments required of the physician who is to deal with the weighty questions of health and disease, and of life and death, is being steadily raised. The Illinois State Board of Health is now regarded as the pioneer in this work, and it is quoted as authority both in this country and abroad. Since the passage of the amended act—in force July 1, 1887—the Board has refused licenses to itinerant vendors of nostrums, with show accompaniments. The amount of these licenses would aggregate over \$20,000, but the sum which the itinerants would fleece from the credulous would figure up hundreds of thousands a year.—*Indiana Medical Journal*, March, 1889.

**Army Medical Board.**

An Army Medical Board will be in session in New York City, N. Y., from May 1 to 31, 1889, for the examination of candidates for appointment in the Medical Corps of the United States Army, to fill existing vacancies, of which there are now seven, and an additional one will occur in July. Persons desiring to present themselves for examination by the Board will make application for the necessary invitation to the Secretary of War, before May 1, 1889, stating the place of birth, place and State of permanent residence, and enclosing certificates based on personal knowledge from at least two persons of repute, as to American citizenship, character and moral habits. Testimonials as to professional standing, from Professors of the Medical College from which the applicant graduated, and of service in hospital from the authorities thereof, are also desirable. The candidate must be between 21 and 28 years of age, and a graduate from a *Regular Medical College*, evidence of which, his Diploma, must be submitted to the Board.

Further information regarding the examinations and their nature may be obtained by addressing John Moore, the Surgeon General, U. S. Army, Washington, D. C.

**The Medical Examiners' Bill.**

The Philadelphia *Ledger*, April 1, 1889, refers to the remarkably fair and liberal bill providing for State examination of practising physicians, which was introduced into the Pennsylvania House of Representatives at the instance of the Medical Society of Pennsylvania, and quotes as follows from its issue of March 20 : "A claim is put forward by the doctors of several of the 'new schools' for minority representation in the Examining and Licensing Board. That is a proper claim ; it should be conceded and conceded in the bill as it stands. But the trouble seems to be that, while the 'old school' doctors are willing to concede 'minority representation,' they are not ready to agree to minority control. They are right about this, for the amendment proposed by the 'new schools' of medicine might be easily made to give such a preponderance to less than *one-fourth* of the total number of medical practitioners in the State as would enable them or their representatives in the State Board to overrule the representatives of the other three-fourths." With reference to the amendments made to the Bill, which give an equal representation to all the schools, it says : "It will be observed that since the above article was published the Legislature has so amended the bill that the representatives of three-fourths of the doctors of the State cannot by any possibility be a majority of the Board, and that the representatives of *one-fourth* may, if united, control the Board. This is all wrong ; yet so anxious are the leading physicians of the city to have State examinations that they have agreed to accept the amended bill, though it is unfair to them ; but they ask in return that graduates of medical schools be required to attend a four years' term. This would force the higher education of physicians, and is a course which the better colleges would be glad to have made compulsory. But the Legislature, without regard to 'old school' or 'new school,' ought to make the bill a fair one by reconsidering the amendments made, and should certainly join heartily with the best physicians to raise the standard of doctors admitted to practice in the State so as to get rid of quacks and pretenders in all 'schools,' old and new."

## NEWS.

—Scarlet fever is prevalent at Marlborough, a hamlet near Newburgh, New York.

—The Texas State Medical Association will meet in San Antonio, Texas, April 23-26, 1889.

—The Hospital Collection Fund of New York City amounted to \$52,033.40 during the year 1888.

—Dr. H. C. Wood will deliver the annual address at the coming commencement of the Yale Medical School.

—Dr. R. P. Howard, Dean of the Medical Faculty of McGill University, Montreal, died in Montreal, March 28.

—The Alabama State Medical Association will meet in Mobile, Tuesday, April 9, 1889, and continue in session four days.

—The Nineteenth Annual Meeting of the California State Medical Society will be held at San Francisco, April 17, 18 and 19, 1889.

—The Thirty-ninth Annual Meeting of the Illinois State Medical Society will be held in Jacksonville, Tuesday, May 21, 1889.

—The Eleventh Annual Meeting of the Louisiana State Medical Society will be held in New Orleans, Tuesday, April 9, 1889.

—The Twenty-seventh Annual Meeting of the Mississippi State Medical Association will be held in Jackson, Wednesday, April 17, 1889.

—The Thirty-ninth Annual Meeting of the South Carolina Medical Association will be held in Charleston, beginning Wednesday, April 10, 1889.

—The Western Pennsylvania Medical College held its commencement March 28, and conferred the degree of Doctor of Medicine upon thirty-six graduates.

—Dr. Thomas J. Mays will deliver his third lecture on Pulmonary Consumption a Neurosis, Friday evening, April 12, 1889, at 8 o'clock, in the Philadelphia Polyclinic, Broad and Lombard Streets. Physicians are invited.

—The following numbers of infectious diseases and deaths were reported in New York City for the two weeks ending March 29 (*New York Med. Journal*, March 23, 1889): Typhoid fever, 18 cases and 5 deaths; scarlet fever, 728 cases and 95 deaths; cerebro-spinal meningitis, 4 cases and 1 death; measles, 425 cases and 40 deaths; diphtheria, 403 cases and 91 deaths.

## OBITUARY.

## EDWARD T. BRUEN, M.D.

Dr. Edward T. Bruen, of Philadelphia, Assistant Professor of Physical Diagnosis at the University of Pennsylvania, died March 31, of pneumonia, after an illness of less than a week.

Dr. Bruen was born in Philadelphia in 1851. In early life he attended private schools under the direction of his father, and later entered the University of Pennsylvania, from which he was graduated in medicine in 1873. In 1874 he was elected one of the visiting physicians to the Philadelphia Hospital, and has been a lecturer in the Spring courses at the University of Pennsylvania for a number of years. In 1880 he was elected Demonstrator of Clinical Medicine, and in 1884 was appointed Assistant Professor of Physical Diagnosis in the same institution. He was also a visiting physician to the German Hospital. His contributions to medical literature were numerous; his "Handbook of Physical Diagnosis of the Heart and Lungs," has passed through two editions. He was a member of the Association of American Physicians, of the American Climatological Society, and of the Philadelphia County Medical Society, and of other medical societies. He leaves a wife and two children.

Dr. Bruen's illness was sudden in its onset and proved fatal rapidly. Not long before he was taken sick he delivered the lecture on Nervous Dyspepsia, which appears in this number of the REPORTER, and it has a melancholy interest from the fact that it is probably the last manuscript that he revised before his death.

## JOHN SWINBURNE, M.D.

Dr. John Swinburne, formerly Health Officer of New York City, died in Albany March 29, 1889. Dr. Swinburne was born in Denmark, Lewis county, in 1821, and was graduated from the Albany Medical College in 1846. He was soon made Demonstrator of Anatomy in the College, holding that position four years. In 1861 he volunteered, without pay, as an army surgeon, and served with distinction. In 1864 he became Health Officer of the Port of New York, and during his term he established the quarantine service which now exists there. While abroad with his family in 1870, he took charge of the American ambulance service in Paris during the Franco-Prussian war.

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